range the mean may be the same for many hours. Again, in comparing the hours of sunshine, it must be borne in mind that San Remo is seven or eight degrees south of Falmouth, and the days are considerably longer at the former than the latter place. The same months are compared, but not the same seasons. This, of course, should be all in favour of San Remo, as it is the winter months which invalids wish to escape from; but practically it is not so, as the rapid fall of temperature about sundown on all the stations on the Riviera drives the invalid indoors before sunset, and thus makes the southern day as short as the northern one, where no such changes of temperature occur. Moreover, the therapeutical value of sunshine has not yet been scientifically made out. It has an important psychical effect which of course is beneficial to invalids, but it is its frequency rather than its intensity, its quality rather than its quantity, which is beneficial.

Even the excess of rainy days, that is, days on which some rain falls (the quantity should be given) at our English stations is not such a formidable condemnation of them as at first sight appears. A rainy day is a less evil than an east wind or a mistral, which are dry winds and accountable for much of the dryness of the Riviera atmosphere (records of which ought to be given in all climatic data), and is less injurious, more tolerable to bear, and more easily surmounted by domestic arrangements at home than abroad, and it is the nature of the soil much more than the relative humidity of the atmosphere which is of importance. The humidity of Falmouth as given by Sir Edward Sieveking for the winter months, 83.6, compares favourably with that of midland England, which is 90.2, and it is no doubt still lower at our more eastern stations where the rainfall is much less than at Falmouth.

Meteorological instruments are at best rude guides to climate, and a more delicate test is to be found in the vegetation, as plants indicate not only the minimum temperature and atmospheric humidity, but also the nature of the soil. It is time moreover that this question of climates should be decided by clinical observation, rather than theoretical demonstration. A set of tables showing some useful clinical results would do more to establish the claims of places at home or abroad to the confidence of medical men than the mere opinions of advocates "fashionable" or otherwise. There is a large class of invalids who stand in need of a good winter climate, but who cannot go to the "fashionable" stations abroad on account of expense, or family or business arrangements. Children are especial sufferers in this respect, and if our own statious are not quite equal to the more distant ones, we shall do well to make the most of them, and if we must make comparisons, let it be with other parts of our own country, especially with our great smoky towns, from which invalids have most occasion to escape. If we do this we shall probably find slight differences in meteorological conditions as demonstrated by instruments, but we shall be certain of more sunshine, fresh air, and restfulness for body and mind. The Mediterranean stations are not available for more than one or two per cent. of our invalids who require good winter quarters, and we should be grateful for any additions to our much too limited list of home stations. Our much abused climate has bred up the strongest, healthiest, and most energetic races of the world, and it is only its rougher features which require to be tempered to the wants of our invalids in winter. I have visited the Mediterranean Stations from Tangier and Malaga to Corfu and Cairo in the winter months, and I do not therefore write from prejudice or ignorance, but from experience of our own winter resorts as compared with them.

TOXICOLOGICAL MEMORANDA.

TOXIC EFFECTS OF ATROPINE DROPS.

One or two letters on this subject have recently appeared in the Journal. Cases of atropine delirium similar to the one related by Dr. Tyson are not very uncommon in ophthalmic practice. Children are most liable to suffer in this way, but occasionally the same symptoms result in the adult from the use of atropine drops. As Dr. Chaldecott indicates in the Journal of November 9th, the poisoning is due, not to the atropine really necessary for the eye, but to the excess which runs down the lachrymal duct into the throat.

My object in writing now is to draw attention to the fact that these alarming results can, in my experience, be entirely prevented by using atropine in the form of ointment whenever it has to be applied repeatedly to the eye. Atropine (not the sulphate) is, I understand, soluble in warm vaseline, so that an ointment of any ordinary strength (say four grains to the ounce) can be readily prepared. A small piece of such an ointment introduced inside the lower lid on the tip of a camel-hair pencil will act on the eye quite as powerfully as an aqueous solution of the same strength. For the past two or three years I have always ordered atropine in this form, and have not met with a single instance of atropine poisoning following.

I need hardly say that, for ordinary purposes of ophthalmoscopic examination, atropine or homatropine drops are preferable to ointment, since the drops of oil from the latter keep floating over the surface of the cornea for a considerable time, and prevent a good view of the fundus. It is in cases where the alkaloid has to be used repeatedly that I should recommend an ointment in preference to an aqueous solution of atropine.

Queen Anne Street. R. Marcus Gunn.

PATHOLOGICAL MEMORANDA.

DUODENAL ULCER AFTER A BURN.

From the records of a great many cases of this lesion, it appears that:—1. It may occur three or four days after a burn or scald, or may be delayed for many weeks. 2. In two cases it followed not a burn but a frost-bite. 3. In only one case (P. Hewett) is it recorded that the raw surface of the burn took on an unhealthy action at the time when symptoms of duodenal ulceration were first observed. 4. Not one case showed true pyæmic abscesses elsewhere: nor, in most of the cases, is there any record of marked signs during life of pyæmia or septicæmia: nor are there other lesions found *post mortem:* the duodenum suffers alone.

Many theories have been suggested as to the causes of this lesion: that it is due to an "acute oligocythæmia"; to dissolution of the red blood corpuscles; to the administration of ardent spirits immediately after the burn; to septic infection, aided perhaps by self-digestion; to embolism. But the experiments of Brown-Séquard, who found that section of the lumbar cord, or of the sciatic and anterior crural nerves, prevented congestion and ecchymoses of the viscera, in dogs whose lower extremities had been burned, show that the nervous system is concerned in the production of this lesion. The frequent occurrence of invagination in burnt children, and the case of sudden acute tympanites after a burn, recorded by Dr. Gibb, point in the same direction.

Perhaps this congestion or ulceration of the duodenum after a burn is in some cases akin to the congestion and suppuration of the parotid in injury or disease of the pelvic or abdominal viscera; a lesion which may be associated with septic infection, but is associated also with reflex nerve influences, and is a solitary focus of inflammation in nine cases out of ten. The duodenum lies closer than any other part of the intestines to the great sympathetic plexuses: it is not fanciful to suppose that the first step toward ulceration is made by some alteration or suppression of its secretions, brought about by the influence of the nervous system.

Wimpole Street, W. Stephen Paget.

TERATOLOGICAL MEMORANDA.

FŒTUS, WITH DUPLICITY OF RIGHT LOWER EXTREMITY: ARM PRESENTATION.

The following case was attended by me on the night of the 10th July, 1880:—

M. B., a poor laundress, of Labbar, Malta, 32 years of age, being at the end of her second pregnancy, after a good day's work, on July 10th, came home, and shortly afterwards labour pains began. The midwife of the district was called in, and attended her for nearly two hours, during which time the pains became severe, and the membranes were ruptured. On examination the midwife discovered a preternatural labour, and asked for a medical man. I was called at about 10.30 p.m., and found the pains severe, the general state of the woman satisfactory, and the fœtus in the second anterior dorsal position, with protrusion of the left arm. There was moderate hæmorrhage, and the os uteri not fully dilated. When it became more dilated I performed, without difficulty, the turning of the child.

I brought out a large female child with three legs, the super-

numerary limb springing out from the internal upper part of the right thigh, forming at the place of insertion a big projection. The third leg was about a quarter of an inch shorter than the two normal lower extremities, but much thinner. It presented five digits, besides the great toe. The woman recovered in a short time, but the child died after two days through congenital debility. The mother absolutely refused to allow a *post-mortem* examination, or to let the child be kept in the museum of the Central Hospital. I cannot, therefore, give any description of the anatomical connections of this supernumerary leg with the rest of the body.

Malta. G. F. INGLOTT, M.D., D.M.O.

OBSTETRIC MEMORANDA.

TWIN PREGNANCY; A HEALTHY AND A MACERATED FŒTUS.

ON September 1st, 1889, I was called to Mrs. B., in her second labour, and one month before she expected. On examination I found the proverbial "bag of shells" presenting, and also a brown grumous discharge. I told those present that the child would probably be dead. After a slight interval the pains recurred, and a healthy sac presented, which I ruptured, and a small healthy boy was soon born. For a moment the first presentation puzzled me, but on putting my hand on the abdomen I found a large mass in the uterus, which was quickly extruded, and presented a fairly healthy, though small, placenta, with two cords, to one of which, withered down to its insertion, a macerated four to five months' male fœtus, still in its sac, was attached. The placenta on this side had a patch of fatty degeneration.

Remarks.—Since her first confinement, five years before, the mother had had two miscarriages; and in the present pregnancy, from the second month to delivery at eight months, she had suffered from severe salivation, spitting as much as two pints in twenty-four hours for some days. Could this have caused the death of one fœtus in any way? The eight months' fœtus died at one month of bronchitis and pertussis. No history of syphilis in family. HERBERT V. RAKE, M.R.C.S.Eng., L.S.A.

Fordingbridge.

CLINICAL MEMORANDA.

INFLAMMATION OF COWPER'S GLANDS IN DENGUE.

IN the JOURNAL of January 4th, 1890, I read in the special correspondence from Vienna a report of a case of measles related by Dr. S. Rona in which this complication occurred, and you mention "such a complication has not hitherto been recorded in connection with an acute exanthem." Allow me to inform you that in the outbreak of dengue which has been endemic here for four years, I have had frequent cases in which this complication has occurred, and surely dengue, with its chest eruption, etc., must be looked on as an exanthem. I have reported cases in which there was acute orchitis or acute inflammation of Cowper's glands and ducts in the male, and acute ovarian inflammation and pyosalpinx in the female.

I brought this matter before the British Medical Association at their meeting in Dublin in 1887. The same thing has occurred in pet dogs that have taken the disease from actual contact with patients, profuse urethral discharge in dogs and vaginal discharge in bitches. Epistaxis in men and profuse flooding in females are also complications that I have been called on to treat in dengue.

JOHN RINGWOOD, Medical Officer, Kells Fever Hospital, Ireland.

ACUTE PEMPHIGUS.

SOME cases which have recently been under my care seem to point to an acute pemphigus.

W. G., aged 3 years, was taken with diarrhœa and sickness on October 23rd. On October 26th I saw the case first; there were about thirty large vesicles scattered all over the body and extremities; they had red bases, were painful, and where the crusts had been rubbed off in the more advanced ones, large excoriations were left. Temperature 103°. This child remained extremely ill for three or four days, and was convalescent on November 7th.

E. G., aged 6, was seized with convulsions on October 29th, and next day developed many vesicles about the size of a pea; there was diarrhœa and sickness. Temperature 104°. Convalescent by November 4th. This child had ascarides.

L. G., aged 11, had diarrhœa and sickness on November 1st. Temperature 102°; and on November 3rd about a dozen vesicles appeared. Convalescent November 6th.

These cases were all children in one family, and in each case the vesicles have left a purple stain, which is fading gradually.

Dulverton. G. F. SYDENHAM, M.R.C.S.

THERAPEUTIC MEMORANDA.

TREATMENT OF INFLUENZA.

I FIND, after treating about fifty cases of the disease, that it can be cut short as easily as an ordinary bronchial attack by the following medicines in combination:—Spiritus etheris nitrosi, half an ounce; liquor ferri perchloridi fort., half a drachm; vinum ipecacuanhæ, one drachm; tinctura opii, twenty minims; glycerine, half an ounce; water to six ounces; one tablespoonful of the mixture to be taken every two hours. When the bowels are confined I give three grains of calomel. By this treatment the disease is readily cut short in twenty-four hours, leaving the patient rather weak and slightly affected with a cough, curable by sulphuric acid and opium in ordinary doses. I have seen but one case of the gastric form, which I treated successfully on general principles. If the bronchial catarrh were aggravated and extensive, and there were symptoms of great depression and collapse on seeing a case, I would omit the opium and ipecacuanha, and give full doses of iron and nitrous ether.

Accrington. C. R. ILLINGWORTH, M.D.

REPORTS

ON

MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

GREAT NORTHERN HOSPITAL.

CASE OF ANKYLOSIS OF TEMPORO-MAXILLARY JOINT: EXCISION OF THE CONDYLE AND NECK OF THE JAW.[1]

(By HERBERT WILLIAM ALLINGHAM, F.R.C.S., Surgeon to the Hospital.)

G. F., aged 8, was brought by his mother, who gave the following history: About three months previously he had tumbled from a wall ten feet in height and had fallen upon the point of his chin, making a wound about an inch in length just below the symphysis. He was taken to a neighbouring chemist, who treated the wound; but from the time of the accident the lad complained, whenever he moved the jaw, of pain in the region of the right temporo-maxillary joint. Moreover, the jaw became stiff, and continued to grow even stiffer.

On examining him carefully, I found the following condition: There was a scar an inch in length below the symphysis, but I could not discover any signs of fracture about the horizontal or vertical ramus. The right temporo-maxillary joint, however, seemed tender to the touch, and the condyle was more prominent than that on the left side. He could open his mouth only half an inch, and could not advance the lower jaw, nor was he able to effect any lateral movement. He complained of occasional pain when he bit on any hard substance, and could not protrude his tongue. Accordingly, under ether I forced open the jaw; but in a fortnight it returned to its former stiff condition. I repeated the operation and told the lad to keep the jaw open by means of a cork. Again I was disappointed; once more the jaw reverted to its contracted state, although the cork treatment was continued for over a month. I then left him alone for quite two months, as he complained of pain about the joint. At the expiration of this period I decided to excise the condyle and neck of the jaw.

On December 7th, 1887, chloroform being given, an incision was made over and along the zygoma for about two inches, and downwards along the posterior margin of the jaw for the same distance. The skin was dissected downwards off the parotid fascia, and this fascia and the masseter were then divided from the lower border

[1] Shown at the Medical Society of London.